European Journal of Health Law **6**: 235-248, 1999.

The Future of Informed Consent in British Common Law

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Key words:
Informed Consent, common law of torts, Bolam test, causation, European Convention on Human rights and Biomedicine, Slippery slope

Abstract:
Within the common law world, the use of the term informed consent implies the American doctrine. Informed consent as a doctrine is not part of the law in the United Kingdom. However, it is possible to predict a way forward in disclosure cases yet to be heard in the courts of the United Kingdom. These predictions are based on current developments in the common law in the United Kingdom as well as those in Canada and Australia, on the European convention on Human Rights and Biomedicine and on trends within the medical profession itself in the light of the Bolam test.

1. Informed Consent as a Doctrine in Common Law Jurisdictions

Medical and surgical procedures constitute *prima facie* assaults unless authorised by the patient's consent.[1] A patient is unlikely to give consent for an operation to be performed without reasonable care. Nevertheless, surgery carries inherent risks irrespective of quality. For this reason, knowledge of the risks involved is important to the patient if it could affect the decision whether and in which way to receive treatment.[2] If a risk eventuates, the plaintiff may claim that consent was invalidated by the surgeon's omission to warn of that risk. The injured patient would then allege that had the information been given, consent to the operation would have been withheld and hence injury would have been avoided.

Informed Consent developed as a legal *doctrine* in America in order to extend the civil liability of medical practitioners as well as to promote patients' rights; this was done through negligence principles by using the doctrine to describe the standard of care in American tort law.[3] This was the birth of the common law doctrine of informed consent. Although many non

common law countries do recognise principles of medical consent based on information disclosure, this paper will consider the doctrine in the common law world. This is because the law in the United Kingdom — particularly medical law — will be influenced more by the law in other common law jurisdictions than it will be influenced by civil law jurisdictions.

Because it is a legal doctrine, the term 'informed consent' is neither redundant nor tautological, even though consent in the absence of information is conceptually redundant. The term must be seen in the context of the operation of the common law. Its judicial application is a way of balancing the physician's legal duty to provide information with the patient's right to make an autonomous choice. Perhaps the most fitting definition of the doctrine is in *Harnish v Children's Hospital Medical Center*:

> ' ... a physician owes to his patient the duty to disclose in a reasonable manner all significant medical information that the physician possesses or reasonably should possess that is material to an intelligent decision by the patient whether to undergo a proposed procedure.'[4]

In *Canterbury v Spence* it was held that

> '[t]rue consent to what happens to one's self is the informed exercise of a choice, and that entails the opportunity to evaluate knowledgeably the options available and the risks attendant upon each.'[5]

What became elaborated as the doctrine of informed consent was defined in *Canterbury v Spence* as the right to be informed of material risks inherent in, and alternatives to, proposed medical procedures. This in itself begged the question, 'what constitutes a material risk?'

In the law of insurance in the United Kingdom, the non-disclosure of a material fact invalidates the policy; a material fact is one which would influence the decision of the prudent insurer whether to insure against risk.[6] Similarly, according to the doctrine as set out in *Canterbury v Spence*, a material risk is one to which 'a reasonable person in what the physician knows or should know to be the patient's position, would be likely to attach significance ... in deciding whether or not to forego the proposed treatment.'[7] This suggests that if Britain were to adopt the doctrine of informed consent, a test for materiality not unlike one inherent in the doctrine, would be built into the existing common law. It also tells us that the definition of materiality is inseparable from the test for legal causation.

2. Causation

One of the purposes of tort law is to facilitate the compensation of a victim for damage caused by another's fault. Having established the existence of an actionable injury, the court asks, 'what was the fault?' Here we are dealing with incomplete consent rather than a total lack of consent. Any such claims are now normally argued in negligence in the common law world, because lack of general consent gives rise to an action in assault.[8]

Cases based on informed consent turn on causation. Pleadings would allege that the treating physician was negligent in omitting to warn the patient of the material risk which eventuated. The court will then consider whether the practitioner's omission caused the injury. An affirmative answer comes from persuading the court that but for that omission, the patient would not have undergone the treatment. Considering causation from the patient's viewpoint means that the doctrine of informed consent has been adopted, though it is often modified to fit the strictures of the common law of torts in a particular jurisdiction.

The doctrine has been adopted in other common law jurisdictions, notably by courts in Canada and in Australia which have common law systems analogous to that in Britain. This paper considers how the common law in Britain has reacted to that right outlined in *Canterbury v Spence* and will argue that that while the consent principles inherent in the doctrine may be incorporated into British law, importation of the wholesale doctrine *per se*, will continue to be resisted. This argument is based on incrementalism. Because common law jurisdictions are inherently comparative, it is possible to predict a gradual change in the law. In this instance, such a prediction will be based on three facets of the common law: its ability to consider both academic opinion and the law in analogous systems, its compulsion to follow precedent and its reaction to external influences.

It is appropriate simply to note ability of the common law to take academic opinion into account. Indeed, this was the mechanism by which the doctrine was set out in *Canterbury v Spence*.[9] This tendency, along with the predominant view among British academics in the field, strongly suggests that were the judiciary to consult academic opinion on the matter, that opinion would be in favour of testing the matter relative to the patient's rights. Secondly, when British courts consider the law in other parts of the common law world, they find that the doctrine has been imported in those jurisdictions. For this reason, we must consider the way in which the doctrine was adopted elsewhere in order to shed further light on the reason behind British rejection of the doctrine. This will form a basis from which to argue that while the principles inherent in the doctrine may be adopted, the doctrine itself will be

resisted because of the slippery slope it threatens.

3. Routes to Adoption: Canada and Australia

Informed consent has been adopted in Canada and Australia. In Canada the two component parts were stated as follows in *Kueper v McMullin*:[10] was the risk a material one which ought to have been disclosed to the patient and, if so, would a reasonable person, having been fully informed, have consented to the procedure? This depends on the type of testing used by the court and 'materiality' in Canada was considered a 'modified objective' or 'apparent subjective' inquiry in *Reibl v Hughes*.[11] This dispensed with the problem of subjective hindsight by asking what the prudent patient would have decided in this patient's situation if given the information on the risk which eventuated. The plaintiff's apparent desire for knowledge comes into play as indicative of what the doctor ought objectively to have known of the subjective patient's information needs.

In *Rogers v Whitaker*[12] the High Court of Australia categorised the matter as an informed consent case and rejected the evidence of accepted medical practice as conclusive, considering it as merely a useful guide to the court. The case turned on whether the amount of information the doctor had disclosed complied with the standard of care. This is an example of the citing of patient autonomy to adopt the doctrine of informed consent by considering what the particular plaintiff would have wanted to have been told and, hence, what information she was entitled to expect from the practitioner. The court considered materiality in a similar way to the Supreme Court of Canada, yet rendered the test more subjective by considering it from the point of view of the patient's desire for information. The Court then translated that desire into an expectation of the medical practitioner and hence as the practitioner's legal obligation.

4. The Path of Rejection: the United Kingdom

In medical negligence cases, courts in Britain employ the tests set out in *Bolam*[13] and in *Hunter v Hanley*.[14] What has become known as the *Bolam* test is a common law elaboration of the tests set out in these two cases and 'may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice adopted at the time as proper by a responsible body of respectable medical opinion.'[15] These tests inhibit importation of the doctrine because they test negligence relative to the medical profession rather than relative to the patient's point of view. Judiciaries view materiality of

information from the perspective of the reasonable doctor rather than the reasonable patient in the actual patient's position. This means that, according to the *Bolam* test, the relevant question is 'what can the reasonable doctor be expected to have disclosed to this patient?' rather than 'what would the reasonable patient expect to be told?'

In *Sidaway v Bethlem Royal Hospital Governors*,[16] the House of Lords held that informed consent appeared 'contrary to English law'[17] and that the *Bolam* test was appropriate to test the standard of information given to a patient. Like that in Australia, the test for causation in Britain is a subjective one in the law of Torts. Judicial rebellion is against the wholesale doctrine rather than the consent principles it embodies, as well as against the slippery slope it threatens in the form of this inherently subjective test for causation.[18] Yet in the years that have elapsed since the *Sidaway* judgement was handed down, much positive critique has been given to the dissenting judgement of Lord Scarman. Indeed, not only have academics supported his approach, the British Medical Association (BMA) has adopted it as an ideal mode of practice.

5. Lord Scarman's and the Patient's Right

Lord Scarman argued that a doctor's duty to supply information on risks and alternatives stems from the patient's right.[19] The BMA drew on Lord Scarman's dissenting opinion in *Sidaway*[20] in which he set out the admittedly ideal 'prudent patient' test regarding information disclosure as that which 'allows the patient to make a rational decision.'[21] This is curious precisely because it was a dissenting opinion. If the ideal of the profession's trade union is not the law, this says much about the direction in which we might see the law to be moving. It also speaks volumes about how the medical profession sees the ideal legal position — which is not as much in the interests of the profession as the present English and Scottish positions. This is significant in a system in which the practices of the profession drive the legal acceptance of those practices in the law of negligence.

Therein lies a reasoning on which the professional standard can be kept afloat in the United Kingdom while at the same time admitting informed consent principles. The National Health Service Patients' Charter of 1991 states that every citizen has the right 'to be given a clear explanation of any treatment proposed, including any risks and alternatives.'[22] Lord Scarman did not draw on the Patient's Charter or any similar document, assuming that the right exists of itself and gives rise to the doctor's duty.

Yet in tort law, the doctor's duty stems from the standard of care. It is

correct to argue that a duty presupposes a right, but the slippage made by Lord Scarman comprised putting forward a causal connection between right and duty. However, the relationship between duty and right is symbiotic and the beginning point of that relationship is the judicial definition of the professional standard of care. The relationship between right and duty begins when the relationship between doctor and patient begins. Any argument will begin with the existing definitions and tests for the standard of care. One facet of that standard is the right of the patient and the duty of the practitioner, as a single indivisible unit.

6. The 'Erosion' Cases

By 'erosion' we mean those judicial decisions which seemed to indicate that the solidity and sanctity of the *Bolam* test was in jeopardy. In these cases the plaintiff proved his or her case precisely by using the *Bolam* test. Admittedly these decisions were been made by courts inferior to the House of Lords, yet it is significant that none of them have been appealed. While they do not set any new precedent, they do indicate that the *Bolam* test is now useful to the plaintiff.

In *Sidaway* the House of Lords accepted the need for information and retained the power to determine the adequacy and materiality of information given, based on a responsible body of medical opinion. It was held that the standard of care did not include the doctrine of informed consent in these circumstances. Accordingly, the court did not need to consider causation. Subsequent cases, however, point to a shift in policy appropriately reflective of a shift in medical opinion. The *Bolam* test is not new; neither is it undergoing erosion. What these 'erosion' cases show is that a test traditionally regarded as protective of doctors may form part of the plaintiff's armoury.

Smith v Tunbridge Wells HA[23] concerned the negligent failure to warn a patient of the possibility of impotence and incontinence following the so-called Wells operation. It was found that a responsible body of medical practitioners would have given such a warning — indeed that to give a warning was the *only* reasonable course of action.[24] On factual causation, medical evidence was used to establish that the impotence actually suffered was caused by the Wells operation itself. The test for legal causation was a subjective one: whether or not Mr Smith would have declined the operation had he known of the risk involved. Morland J said, 'I am entirely satisfied that if the risk of impotence had been explained to the plaintiff, he would have refused the operation.'[25] To arrive at this conclusion, he considered the plaintiff's age (28), family disposition (he was married) and the fact that he

had already lived with the condition for eight years. For this, medical evidence was precisely the 'useful guide' for the courts that it had been in *Rogers v Whitaker*.[26]

A similar logic was put to use by Mr Justice Rougier in *McAllister v Lewisham*.[27] Again negligence was established; it was held that the evidence of the expert witness for the defence contained an inherent paradox in that the witness made no criticism of the surgeon's failure to mention the risk of sensory deficit, yet that risk stood at 100 per cent.[28] Weighing up the evidence and assessing its internal consistency, the judge was able to hold that 'those who say that the warnings given ... were inadequate are right and there has not been shown to me on the evidence any reputable body of responsible opinion to the contrary.'[29]

Rougier J called the causation inquiry the 'hardest part' because it involves hypothesis and hindsight. The evidence established that the operation was the factual cause of the injury. Then, as in any disclosure case, it fell to the plaintiff to establish that with the information, she would have declined the operation. Mrs McAllister's 'innate honesty' prevented her from speculating as to what she would have done had she known of the risks, but the court was able to make a finding in her favour nonetheless.

Indeed, the court considered the medical evidence in relation to Mrs McAllister's personality (sensible and independent-minded) and lifestyle (her job and the independence it gave her).[30] Medical evidence was used to establish that her medical condition was advancing slowly; that information was used along with the court's assessment of her personality and the plaintiff's assertion that she would probably have taken a second opinion had she known of the risk, to hold that this patient would have declined the operation.

When comparing, as we are, this case to those in Canada and Australia, what is notably absent from the judicial test is an assessment of the reasonable person in the plaintiff's position. This indicates that the test is that much more subjective in England than it is in Canada, but remains sceptical of the patient's hindsight. The next case casts this statement in a slightly more dubious light, because as in the preceding two cases, the court tried to disregard the hindsight of the patient. However, when trying to assess what a plaintiff would have done had he known of the risk, the court made greater use of medical evidence and the tendency of patients in similar situations. This suggests that the court tried to inject a little more objectivity into the test for legal causation through a more objective assessment of the evidence. As the next two cases will show, this occurs only if the court is unconvinced by the subjective approach.

Newell and Newell v Goldenberg[31] involved a vasectomy operation which

recanalised and, hence, to a fourth pregnancy for the Newells. They alleged that had they known of the risk of recanalisation, Mrs Newell would have had a sterilisation operation too, so erring on the side of caution. After considering the views of experts called for both sides, Mantell J found the defendant negligent on the ground that, 'given knowledge of the risk, the only argument which can be offered against giving a warning is the concern that the confidence of the patient and his partner might be undermined with a corresponding increase in anxiety during and following the sexual act.'[32]

The judge was taking account of patient-centric factors in this assessment of the standard of care. The court then moved on to causation. True to the subjective test, the court would have to be satisfied that the Newells would have taken a different course of action had the information been given. On the subjective side of the inquiry, Mrs Newell asserted that had they known of the risk, she would have undergone a sterilisation operation. Mantell J observed that this statement was made with the benefit of hindsight; indeed that 'the operation on Mrs Newell only took place after these proceedings had been put in train.'[33]

For that reason, the court had to consider a more objective form of inquiry to resolve the causation issue. The court noted that the surgery on Mrs Newell was contraindicated on medical grounds and that would have outweighed arguments in favour of a joint sterilisation which was, according to expert evidence called by both sides, almost unheard of in medical circles. This case shows that medical evidence can be useful to the court in the inquiry into causation where too much reliance is placed on the hindsight of the plaintiff. It also shows a tendency towards a Canadian-style test at that level.

In *Lybert v Warrington HA*[34] the Court of Appeal[35] again had to consider a failed sterilisation operation. It was concluded that insufficient warning had been given of the prospect of failure. Further, the court found that there was an 'inherent likelihood' that with a proper warning that a sterilisation may fail, the couple would have used other methods of contraception while they waited for the plaintiff to undergo a hysterectomy.[36] Lord Justice Otton drew this conclusion from the previous history of the plaintiff and from the fact that she had already undergone three caesarean section operations and had requested a hysterectomy to take place at the same time as the last of those three caesarean sections. She was advised that this would not be possible, so consented to a tubal ligation while waiting for a hysterectomy to be performed as a separate procedure.

This decision shows a return to a more subjective test, with medical evidence useful only if the plaintiff's testimony lacks credibility — by being based on hindsight, for example. In this case, there was no such lack of credibility and hence medical evidence of the consequences of a fourth

caesarean section, was again the 'mere useful guide' that the court found it to be in *Rogers v Whitaker* in Australia. It cannot be emphasised too strongly that in tort law in Britain, the test for legal causation is as subjective as that in Australia.

In Scotland in *Goorkani v Tayside Health Board*[37] the pursuer persuaded the court that the reasonable medical practitioner would have warned of the risk of sterility from taking a particular immunosuppressive drug for more than three months. He did so on the basis of medical evidence. This assessment was based on the established fact that the pursuer was not told of the risk and on the medical facts pertaining to the actual risk of sterility.[38] This meant that the pursuer had to establish causation.

The medical evidence established factual causation. However, the medical evidence established that without the drug the pursuer would have gone blind; hence it was held that legal causation was not established because the objective pursuer would have accepted that risk had he known of its existence.[39] Clearly the test for legal causation is a subjective one and, hence, medical evidence constitutes a guide for the court which, when placed alongside the pursuer's own evidence and subjective circumstances, aids the making of a decision by the court.

Taken together and considering legal causation, these cases indicate a greater judicial sensitivity to patients and show *Bolam* to be useful to plaintiffs. That courts do not take plaintiff's evidence at face value shows a similar scepticism of hindsight and favour for apparent-subjective testing as adopted in Canada, but only if the use of a subjective test for legal causation in unconvincing.[40] Assessing 'materiality' relative to current medical practice means that as the medical profession acknowledges a greater need for patient autonomy, courts will have to take the patient's point of view increasingly into account under the *Bolam* test.

This adaptability to current practices is considered the strength of the test; it has the advantage of keeping apace with medicine itself. As the ideas of the reasonable medical professional gravitate towards more fully informed consent, so these ideas will be given judicial sanction. Given the *Patients' Charter* and documents like the *European Convention on Human Rights and Biomedicine*, the medical profession and the law will move in the same direction.

7. The European Convention on Human Rights and Biomedicine

The *Convention* was opened for signature on 4 April 1997. Although the

United Kingdom has not yet taken up that invitation, it remains another arrow in the quiver of patient autonomy. Article 5 states the general rule that 'an intervention in the health field may be carried out only after the person concerned has given free and informed consent to it' and that '[t]his person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.'

The use of the words 'informed' and 'consent' together suggests to common law jurisdictions that it is the doctrine that is being invoked. Because England and Scotland are common law jurisdictions, we must consider the possibility that it is the doctrine which is being considered by the use of 'informed consent' by the Council of Europe. The Convention is open for signature by, *inter alia*, Australia, Canada and the USA as non-member states which 'have participated in its elaboration....[41]' Considering that informed consent is a doctrine of American construction and Canadian and Australian elaboration, it is probable that what delegates had in mind during the process of formulating Article 5 was the doctrine as articulated in their jurisdictions.

Paragraph 35 gives some indication of the meaning of 'informed consent'. While this reflects the opinion of the Steering Committee of Bioethics, it does not constitute a binding instrument. Aside from the Explanatory Report to the Convention, there is no publication setting out the rationale of each clause and the preparatory work of Steering Committee remains classified and restricted.[42] However, because the Convention 'it' does not constitute a binding instrument, the term 'informed consent' would need to be interpreted according to national law. That said, it remains possible to speculate on the future of informed consent in Britain on the basis of the argument that the common law is influenced by academic writings, the existing body of case law as well as other national and international codes.

8. British Incorporation of Human Rights

The present government is set to incorporate the European Convention on Human Rights. It is a short step to do the same with the Convention on Human Rights and Biomedicine. The ECHR is unique among international instruments insofar as litigants may be private individuals as well as signatory states; the same will apply to that on biomedicine.

In practice terms, an analogy can be drawn with cases which went through domestic courts to Strasbourg. For example, *Campbell and Cousans v United Kingdom*[43] was a case which concerned corporal punishment in schools. The case was ultimately won in Strasbourg by the plaintiffs, but the very fact of

bringing the matter to the European Court of Human Rights impelled the British legislature to amend domestic law. The analogy is that if a so-called informed consent case were to be brought before the same court, perhaps the British legislature would amend domestic law in the same manner as occurred in respect of corporal punishment in schools.

Given the existing body of case law on the issue, it is argued that statutory change is an improbable route to the adoption of informed consent. However, by analogy with the cases such as *Campbell and Cousans v United Kingdom,* one can infer that there may be another court of appeal after the House of Lords. To speculate on how the court in Strasbourg would decide such a case, one should take into account the reflexivity of the common law, the influence of European law to which Britain is a signatory and the comparative nature of medical jurisprudence. Indeed, the same argument can be made in respect of the House of Lords.

The Convention is likely to be interpreted according to national law. This is because while it was drafted under the responsibility of the Council of Europe Secretariat and reflects the opinion of the Steering Committee of Bioethics, it is not a binding instrument. It is therefore necessary to continue to argue in terms of influence. Such influences include that of the European Convention on Human Rights and Biomedicine, of the law in America, Canada and Australia and of existing trends within medicine as seen in the context of the *Bolam* test. These influences, taken together, allow us to predict the arrival of an increasingly patient-centric standard in disclosure cases.

9. Informed Consent, *quo vadis?*

The very threat of such a case finding its way to Strasbourg will affect domestic law and it is arguable that the House of Lords or the European Court of Human Rights may decide in a plaintiff's favour in the informed consent scenario, but not at the expense of the *Bolam* test. Even if the court in Strasbourg were to decide the matter according to domestic law, the timing of the case will be crucial because of ongoing changes within a medical profession whose praxis is held in such judicial esteem.

There is already a trend towards more comprehensive information disclosure in medical practice, which would accord with the tenets of the *Bolam* test. The 'erosion' cases may be cited in support of this contention. Secondly, the British Medical Association adopts Lord Scarman's dissenting judgement as a practice ideal, which takes account of patients' rights. This judgement also has the weight of academic opinion behind it. Finally, when considering the usual path towards Strasbourg and the reflexivity of the

common law in this context, what can be inferred is the possible desire of domestic courts to preempt a decision in Strasbourg. While the doctrine of informed consent as articulated elsewhere is unlikely to be adopted *per se*, the principles it embodies are gradually becoming the standard by which medical practice is measured by British courts.

This will occur because of a combination of factors. The common law is inherently comparative; within medical law this comparison is of a more international nature. Secondly, the *Bolam* test is flexible as practices change within the medical profession. For this reason, as more comprehensive disclosure becomes the professional norm, this norm will be translated by the courts into an expectation of the medical practitioner. Finally, when we consider the Patients' charter, the citing of Lord Scarman's judgement as an ideal mode of practice and the European Convention on Human Rights and Biomedicine, the logical conclusion is that informed consent will come to the United Kingdom, thought not as a wholesale doctrine. This is because of the slippery slope it threatens, *inter alia* in the form of a subjective test for causation.

The other form of slippery slope has to do with the judicial fear of accepting the doctrine and, by that act, accepting the doctrine in its entirety. In other words, courts may fear that by accepting the doctrine in its original elaboration, they will by that acceptance take on any and all further developments, implications and effects of the doctrine. Considering some American jurisdictions allows one to see just where this could lead: to the inclusion of information on the physician as material information.[44] This might be viewed as an undesirable outcome and so the British judiciaries do not accept the doctrine, particularly with a subjective test for causation already in place in the law of torts. Informed consent cases turn on causation; a subjective test favours the patient. For the judiciary to remain protective of members of the medical profession, they need to resist the doctrine and allow consent principles to develop from within the profession. This will leave the *Bolam* test intact and, eventually, could favour the plaintiff. This judicial process will remain a balanced one.

Notes

1. In *Chatterton v Gerson* (1981) 1 All ER 257, Bristow J held that with the exception of withholding information in bad faith amounting to fraud which vitiates consent, information regarding the broad nature of the treatment is sufficient to render consent real and to place the cause of action in negligence.
2. J R Matthews *Quantification and the Quest for Medical Certainty*. 1996. Princeton University Press.
3. *Salgo v Leland Stanford Jr. University Board of Trustees* 154 Cal. App. 2d 560; 317

P.2d 170 (Cal, 1957) and *Natanson v Kline* 186 Kan 393, 350 P.2d 1093 (1960).

4. *Harnish v Children's Hospital Medical Center & others* 387 Mass. 152; 439 N.E.2d 240, 155.
5. (1972) 464 F. 2d 772, 780.
6. The Marine Insurance Act 1906 requires disclosure of material facts. S18(2) reads, 'every circumstance is material which would influence the judgement of a prudent insurer in fixing the premium, or determining whether he will take the risk.' This section has been interpreted by the case law in *Pan Atlantic Insurance Co v Pine Top Insurance Co* (1992) 1 Lloyd's Rep. 101, (1994) CLY 2698 and *Deutsche Ruckversicherung AG v Walbrook Insurance Co Ltd* (1996) 1 All ER 791. As will become apparent, not only is there no statutory test for materiality in respect of informed consent cases, but jurisdictions apply different judicial tests.
7. *Canterbury v Spence*, Ibid. 772.
8. *T v T* (1988) Fam 52, (1988) 1 All ER 613, *Chatterton v Gerson* (1981) QB 432, (1981) 1 All ER 257, *Hills v Potter* (1983) 3 All ER 716, (1984) 1 WLR 130.
9. Ibid. The court cited Waltz & Scheuneman, 'Informed Consent to Therapy', 64 *N.W.U.L.Rev.* 628, 640 (1970).
10. (1987) 30 DLR (4th) 408, 412.
11. *Reibl v Hughes* (1980) 114 DLR (3d) 1.
12. *Rogers v Whitaker* (1993) 4 Med LR 79, (1992) ALJR 47, (1992) 109 ALR 625.
13. *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582, (1957) 2 All ER 118 which was used as the rationale for the decision in *Sidaway v Bethlem Royal Hospital Governors* (1985) 1 All ER 643 HL, (1984) 2 WLR 778; (1984) AC 871, and which itself drew from *Hunter v Hanley*, cf. note 14.
14. 1955 SC 200, 1955 SLT 213, which was used as the rationale for the decision in *Moyes v Lothian Health Board* 1990 SLT 444, (1990) 1 Med LR 463.
15. *Bolam* (1957) 1 WLR 582, 586-7.
16. (1984) AC 871, 883C-D.
17. Lord Diplock in *Sidaway*, Ibid. note 13, 894.
18. This was stated more firmly by Lord Donaldson in *Re T (adult)(refusal of treatment)* (1992) 4 All ER 649, 663. Such a slippery slope means that once it is found that the duty of care included provision of information on the risk which eventuated, with a subjective test for causation already in place in tort law, the law would be set to become as patient-centric as that of Australia.
19. *Sidaway*, Ibid. note 13, 888.
20. *Sidaway v Bethlem Royal Hospital Governers* (1985) AC 871, 876 et seq, (1985) 1 All ER 643, 645 et seq.
21. British Medical Association. *Medical Ethics Today: its Practice and Philosophy*. 1993. 10-11
22. *The Patients' Charter* 1992, 9; my emphasis. This is supported by M Dean *The Lancet* 341 (April 1993) 883 and by the Medical Defence Union in the United Kingdom.
23. (1994) 5 Med LR 334.
24. Emphasis in original, Ibid. 330, col. ii.
25. Ibid. 341, col. i.
26. Which was cited by the Queen's Bench in *Smith*.
27. (1994) 5 Med LR 343.
28. Ibid. 352, col. ii.
29. Ibid.
30. Ibid. 353, col. ii.
31. (1995) 6 Med LR 371
32. Ibid. 374, col. i.
33. Ibid. 374, col. ii.
34. (1996) 7 Med LR 71.
35. This is significant because the decisions in the previous three cases discussed were

taken by the Queen's Bench Division.

36. Ibid. 74, col. i.
37. (1991) 3 Med LR 33.
38. Ibid. 35, col. i.
39. Ibid. 38, col. ii.
40. This is not unlike the use of the *Bolam* test by the House of Lords in order to determine legal causation on a more objective basis in *Bolitho v City and Hackney Health Authority* 39 BMLR 1.and, importantly, leaving decision in the hands of the courts.
41. See 33(1); these countries had observer status within the Steering Committee of Bioethics.
42. Correspondence by the present author with the Directorate of Legal Affairs at the Council of Europe has confirmed the observer status of these three countries and the fact that their delegates took part in the elaboration of the convention. This correspondence has also indicated that 'informed consent' must be interpreted according to national law as the Convention does not constitute a binding instrument.
43. (1982) 4 EHRR 293; corporal punishment in schools.
44. *Hidding v Williams* 578 So 2d 1192 (La App 1991) concerned alcoholism by the surgeon to be a material risk, even although that risk was not one inherent in the medical procedure *per se*. Consider, in this light, Ralph Slovenko. 'Informed Consent: Information about the Physician.' (1994) 13 *Medicine and Law* 467-472.